I

106TH CONGRESS
2D SESSION

H. R. 4607

To amend title XVIII of the Social Security Act to provide for a prescription drug benefit for Medicare beneficiaries.

IN THE HOUSE OF REPRESENTATIVES

JUNE 8, 2000

Ms. ESHOO (for herself, Mr. ENGEL, Mr. FROST, Mr. GORDON, Mr. DEUTSCH, Mrs. CAPPS, Mr. WYNN, Ms. DEGETTE, Mr. SAWYER, Ms. MCCARTHY of Missouri, Ms. WOOLSEY, Mr. RUSH, and Mr. ACKERMAN) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for a prescription drug benefit for Medicare beneficiaries.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; REFERENCES TO SOCIAL SECURITY ACT.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Prescription Drug Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(c) REFERENCES TO SOCIAL SECURITY ACT.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 2. PROVIDING FOR MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED

''SEC. 1860. ESTABLISHMENT OF PRESCRIPTION DRUG BENEFIT PROGRAM FOR THE AGED AND DISABLED.

''There is hereby established a voluntary program to provide prescription drug benefits in accordance with the provisions of this part for individuals who are aged or disabled or have end stage renal disease and who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government and to be administered by the Director of the Office of Personnel Management (in this part referred to as the 'Director'), except that functions relating to eligibility to enroll, enrollment, and collection of beneficiary premiums under this part shall be administered by the Secretary in coordination with the Director.

''SEC. 1860A. SCOPE OF BENEFITS.

''(a) IN GENERAL.—The benefits provided to an individual enrolled in the program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription drugs (as specified in subsection (b)) dispensed by

any pharmacy participating in the program under this part (and, in circumstances designated by the benefit manager, by a nonparticipating pharmacy), including any specifically named drug prescribed for the individual by a qualified health care professional regardless of whether the drug is included in a formulary established by the benefit manager if such drug is certified as medically necessary by such health care professional, up to the benefit limits specified in section 1860B; and

''(2) charging by participating pharmacies of—

''(A) the price for all covered prescription drugs, without regard to such benefit limit; and

''(B) the price (if any) established with respect to any drugs or classes of drugs described in subparagraphs (A) through (D) or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Covered prescription drugs, for purposes of this part, include all prescription drugs (as defined in section 1860J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription drugs shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) (except to the extent otherwise specifically provided by the Director with respect to a drug in any of such classes).

''(3) EXCLUSION OF PRESCRIPTION DRUGS TO THE EXTENT COVERED UNDER PART A OR B.—A drug prescribed for an individual that would otherwise be a covered prescription drug under this part shall not be so considered to the extent that payment for such drug is available under part A or B (but shall be so considered to the extent that such payment is not available because benefits under part A or B have been exhausted).

''(c) EFFECTIVE DATE OF BENEFITS.—In no case shall benefits be available under this part for prescription drugs for which costs are incurred before January 1, 2002.

''SEC. 1860B. PAYMENT OF BENEFITS.

''(a) PAYMENTS.—

''(1) IN GENERAL.—There shall be paid from the Prescription Drug Insurance Account within the Supplementary Medical Insurance Trust Fund

(hereafter in this part referred to as the 'Prescription Drug Insurance Account' or 'the Insurance Account'), in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription drugs in a calendar year, an amount equal to the Federal payment percentage (specified under paragraph (2)) of the price for each such covered prescription drug.

''(2) FEDERAL PAYMENT PERCENTAGE.—For purposes of paragraph (1), the 'Federal payment percentage' with respect to purchases during a year—

''(A) up to the initial benefit limit specified in subsection (b), is equal to 50 percent or such higher percentage as is proposed by a benefit manager pursuant to section 1860G(c)(8), if the Director finds that such percentage will not increase aggregate costs to the Insurance Account; or

''(B) above the stop loss amount specified in paragraph (3) (or, if greater for a year after 2008, the initial benefit limit specified under subsection (b)(2)), is equal to 100 percent.

If the Federal payment percentage is increased under subparagraph (A), the beneficiary payment percentage is reduced accordingly.

''(3) STOP-LOSS AMOUNT.—The stop-loss amount specified in this paragraph—

''(A) for 2002 is $5,000; or

''(B) for a subsequent year is the stop-loss amount specified in this paragraph for the preceding year increased by the percentage increase (if any) in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the preceding year.

If the stop-loss amount computed under subparagraph (B) for a year is not a multiple of $25, it shall be rounded to the nearest multiple of $25.

''(b) INITIAL BENEFIT LIMIT.—For purposes of subsection (a)—

''(1) FOR 2002 THROUGH 2008.—The initial benefit limit specified under this subsection is—

''(A) $2,000 for each of calendar years 2002 and 2003;

''(B) $3,000 for each of calendar years 2004 and 2005;

''(C) $4,000 for each of calendar years 2006 and 2007; and

''(D) $5,000 for calendar year 2008.

''(2) FOR 2009 AND SUBSEQUENT YEARS.—The initial benefit limit specified under this subsection for 2009 and each subsequent year is equal to the amount specified under this subsection for the preceding year increased by the percentage increase (if any) in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the preceding year.

''(c) ELECTION OF BENEFIT MANAGER.—

''(1) IN GENERAL.—The Director shall establish a process (based upon the process under which a Medicare+Choice eligible individual may elect coverage under a Medicare+Choice plan under part C) under which an individual enrolled under this part elects a specific benefit manager (under section 1860G) that will be responsible for the provision of benefits under this part on behalf of the individual.

''(2) CHANGES IN ELECTION.—Such process shall permit a change in election at least annually and at such other times as the Director may specify, based upon the type of circumstances for which a change would be permitted under part C.

''(3) NONDISCRIMINATION.—Such process shall not permit a benefit manager to refuse the election of any individual, except as the Director may permit in a nondiscriminatory manner based upon legitimate capacity limitations.

''(4) INFORMATION.—The Director shall provide for dissemination of such information as will enable individuals enrolled under this part to make informed decisions about the election of benefit managers.

''SEC. 1860C. ELIGIBILITY AND ENROLLMENT.

''(a) ELIGIBILITY.—Every individual who, in or after 2002, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll, in accordance with the provisions of this section, in the program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by the Secretary in regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section

applied to this part, except as otherwise explicitly provided in this part.

''(2) ENROLLMENT PERIOD.—Except as provided in section 1860E or 1860H, or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period.

''(3) SPECIAL ENROLLMENT PERIOD FOR 2002.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2002 may, at any time on or before December 31, 2002—

''(i) enroll in the program under this part; and

''(ii) enroll or re-enroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(e) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''SEC. 1860D. PREMIUMS.

''(a) ANNUAL ESTABLISHMENT OF MONTHLY PREMIUM RATES.—

''(1) IN GENERAL.—The Director in coordination with the Secretary shall, during September of 2001 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

"(A) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Director in coordination with the Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits that will be payable from the Insurance Account for prescription drugs dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such amount, the Director in coordination with the Secretary shall include an appropriate amount for a contingency margin.

"(B) DETERMINATION OF MONTHLY PREMIUM RATES.—

"(i) IN GENERAL.—The Director in coordination with the Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be one-twelfth of the share specified in clause (ii) of the amount determined under subparagraph (A), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

''(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

''(3) PUBLICATION OF ASSUMPTIONS.—The Director in coordination with the Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

''(b) PAYMENT OF PREMIUMS.—

''(1) PAYMENTS BY DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

''(A) DEDUCTION FROM BENEFITS.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a),

(b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

''(B) TRANSFERS TO INSURANCE ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) DIRECT PAYMENTS TO SECRETARY.—

''(A) ADDITIONAL PAYMENT BY ENROLLEE.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less

than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) PAYMENTS BY OTHER ENROLLEES.—An individual enrolled in the program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe in coordination with the Secretary.

''(C) DEPOSIT OF PREMIUMS.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund.

''SEC. 1860E. SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT RULES FOR LOW-INCOME INDIVIDUALS.

''(a) STATE AGREEMENTS FOR COVERAGE.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

''(A)(i) eligible individuals within the meaning of section 1843, and

''(ii) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare drug beneficiaries (as defined in section 1905(v)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A),

the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

"(B) QUALIFIED MEDICARE DRUG BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

"(i) the coverage period shall begin on the latest of—

"(I) January 1, 2002,

"(II) the first day of the third month following the month in which the State agreement is entered into; or

"(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

"(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare drug cost-sharing.

"(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1860C(a), and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits,

the Secretary (in coordination with the Director) shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.

"SEC. 1860F. PRESCRIPTION DRUG INSURANCE ACCOUNT.

''(a) IN GENERAL.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Insurance Account' (hereafter in this section referred to as the 'Account'). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—The Managing Trustee shall pay from time to time from the Account such amounts as the Director certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g), including expenses of the Director and the Secretary in carry out this part. Any reference in such section to the Secretary in relation to carrying out this part shall be construed to include a reference to the Director.

''(c) CONSTRUCTION.—Nothing in this part shall be construed as authorizing any expenditures from the Account for activities under chapter 89 of title 5, United States Code (relating to the Federal employees health benefits program). No funds appropriated to carry out such chapter shall be used to carry out this part.

''SEC. 1860G. ADMINISTRATION OF BENEFITS.

''(a) IN GENERAL.—The Director shall provide for administration of the benefits under this part through contracts with benefit managers approved in accordance with subsection (b) for enrolled individuals (other than such individuals enrolled in a Medicare+Choice program under part C) in accordance with the provisions of this section.

''(b) APPROVAL OF BENEFIT MANAGERS.—

''(1) AWARD AND DURATION OF CONTRACT.—Each contract shall be awarded for a period of not less than three nor more than five years.

''(2) ELIGIBLE ENTITIES.—Any entity that meets the following criteria is eligible to serve as a benefit manager:

''(A) TYPE.—The entity shall be any entity that the Director determines is capable of administering a prescription drug benefit program.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively and efficiently the benefit administration functions.

''(C) INTEGRITY; FISCAL SOUNDNESS.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have financial resources the Director determines to be adequate to perform services under the contract without risk of insolvency.

''(D) BENEFICIARY PROTECTIONS.—The entity shall have in place safeguards to protect beneficiaries who receive benefits under this

part through the entity, including the following protections:

"(i) CONFIDENTIALITY OF HEALTH INFORMATION.—Have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Director may prescribe.

"(ii) GRIEVANCE AND APPEALS PROCEDURES.—Have in place such procedures as the Director may specify for hearing and resolving grievances and appeals brought by enrolled individuals against the benefit manager or a pharmacy concerning benefits under this part, which shall, to the extent the Director finds necessary and appropriate, include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

"(iii) CLINICAL QUALITY.—Have in place systems for improving clinical quality, including the prevention of drug-drug interactions, assessment of clinical rel-

evance, monitoring and improving compliance, and adoption of information technologies proven to reduce prescription errors.

"(iv) NONDISCRIMINATION IN ELECTIONS.—Not to refuse elections, except as may be specifically permitted under section 1860B(c)(3).

"(3) PROPOSAL REQUIREMENTS.—An entity's proposal for award or renewal of a contract under this section shall—

"(A) include a cost proposal setting forth the entity's proposed charges for administration of the prescription drug benefit;

"(B) include a proposal for the prices of drugs and annual increases in such prices, including differentials between formulary and non-formulary prices, if applicable (and at the entity's election, include a proposal described in subsection (d)(8));

"(C) specify details of proposed cost and utilization management, prescription error reduction, clinical quality, and quality assurance measures;

''(D) be accompanied by such information as the Director may require on the entity's past performance;

''(E) disclose ownership and shared financial interests with other entities involved in the delivery of the benefit as proposed;

''(F) include such other material and information as the Director may require; and

''(G) specify a mechanism to control government and beneficiary costs once the stop-loss provision is triggered.

''(4) EXCEPTIONS TO CONFLICT OF INTEREST RULES.—In awarding contracts under this subsection, the Director may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Director may find necessary to impose) in circumstances where the Director finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

"(c) FUNCTIONS OF BENEFIT MANAGER.—The benefit manager shall (or in the case of the function described in paragraph (8), may) perform some or all of the following functions, as specified by the Director:

"(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

"(A) SCHEDULE OF COVERED DRUG PRICES.—Establish a schedule of prices for covered prescription drugs for beneficiaries. Such prices shall not be subject to administrative or judicial review.

"(B) AGREEMENTS WITH PHARMACIES.—Enter into participation agreements with qualifying pharmacies on terms that—

"(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access) for enrolled individuals obtaining benefits through the entity; and

"(ii) permit the participation of any pharmacy that meets the participation requirements described in subsection (e).

"(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Ensure that the prices established under subparagraph (A), formulary re-

strictions, and the list of participating pharmacies are regularly updated and readily available to health care professionals authorized to prescribe drugs, participating pharmacies, and enrolled individuals.

''(2) TRACKING OF COVERED ENROLLED INDIVIDUALS.—Maintain accurate, updated records of all enrolled individuals (other than individuals enrolled in a plan under part C) who are receiving benefits through the entity.

''(3) PAYMENT AND COORDINATION OF BENEFITS.—

''(A) IN GENERAL.—Administer claims for payment of benefits under this part; determine amounts of benefit payments to be made; and receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

''(B) COORDINATION AND PAYMENT OF BENEFITS.—Coordinate with the Director, other benefit managers, pharmacies and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of

access to and payment for covered prescription drugs according to an individual's plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Director may specify.

''(C) EXPLANATION OF BENEFITS.—Furnish to enrolled individuals receiving benefits through the entity an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(4) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Have in place effective cost and utilization management, quality assurance measures, and systems to reduce prescription errors, including at least the following, together with such additional measures as the Director may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Director finds appro-

priate for operation of such program by an entity other than a State).

''(B) CLINICAL QUALITY.—Have in place clinical quality systems consistent with subsection (b)(3)(C).

''(C) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste.

''(5) EDUCATION AND INFORMATION ACTIVITIES.—Have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription drug benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(6) BENEFICIARY PROTECTIONS.—Have in effect beneficiary protections consistent with paragraph (2)(D)(i).

''(7) RECORDS, REPORTS, AND AUDITS OF BENEFIT MANAGERS.—

''(A) RECORDS AND AUDITS.—Maintain adequate records, and afford the Director access to such records (including for audit purposes).

''(B) REPORTS.—Make such reports and submissions of financial and utilization data as the Director may require taking into account standard commercial practices.

''(8) PROPOSAL FOR REDUCED BENEFICARY COINSURANCE.—At the benefit manager's election, provide a proposal for increased Federal cost sharing percentage (and a reduction in beneficiary cost sharing percentage) for generic prescription drugs, prescription drugs on the benefit manager's formulary, or prescription drugs obtained through mail order pharmacies, which includes evidence that such increased Federal cost sharing percentage would not result in an increase in aggregate costs to the Account.

''(9) OTHER REQUIREMENTS.—Meet such other requirements as the Director may specify.

''(d) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a benefit manager to furnish covered prescription drugs to enrolled individuals. The benefit manager may offer preferential financial terms to pharmacies that agree to be included for the purposes of the initial bid.

"(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

"(A) LICENSING.—The pharmacy shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

"(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Director and the benefit manager shall establish concerning the quality of, and enrolled individuals' access to, pharmacy services under this part.

"(C) ADHERENCE TO ESTABLISHED PRICES.—The total charge for each drug dispensed to an enrolled individual, without regard to whether such individual is financially responsible for any or all of such charge, shall not exceed the price for the drug, as established under subsection (c)(1)(A).

"(D) MANAGEMENT SYSTEMS AND PROCEDURES.—The pharmacy shall—

"(i) have in effect management systems (including electronic systems) and

procedures for carrying out functions under the agreement; and

"(ii) maintain adequate records, afford the benefit manager access to such records for audit purposes, and make such reports as the benefit manager may require to meet its responsibilities under this section.

"(E) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—The pharmacy shall implement effective measures for quality assurance, cost management, and reduction of medical errors with respect to drugs dispensed under the agreement, including maintenance of utilization records and participation in the drug utilization review program described in subsection (d)(4)(A).

"(F) CONFIDENTIALITY PROTECTIONS.—The pharmacy shall have in effect systems to ensure compliance with the confidentiality standards applicable under subsection (b)(2)(D)(i).

"(G) OTHER REQUIREMENTS.—The pharmacy shall meet such other requirements as the Director may impose.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as requiring a benefit manager to pay a particular level of dispensing fees to participating pharmacies or as guaranteeing such a level as would provide for the participation by all pharmacies.

''(e) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of benefit managers and their officers, employees, and agents under a contract under this section.

''(f) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—

''(1) CONTRACT PROVISIONS.—The Director is authorized to include in a contract awarded under subsection (c) such incentives for cost and utilization management and quality improvement as the Director may deem appropriate, including—

''(A) bonus and penalty incentives to encourage administrative efficiency;

''(B) incentives under which benefit managers share in any benefit savings achieved;

''(C) risk sharing arrangements related to benefit payments; and

''(D) any other incentive that the Director deems appropriate and likely to be effective in managing costs or utilization.

''(2) ESTABLISHMENT OF A SECONDARY INSURANCE MARKET FOR RISK.—Insofar as the Director provides for a risk sharing arrangement in contracts under subsection (c), the Director shall enter into or promote arrangements (including the establishment of a secondary insurance market or pooling mechanism) for the appropriate distribution of excess risk among entities offering such contracts.

''(3) CONSTRUCTION.—Nothing in this part shall be construed as limiting the ability of a benefit manager, subject to provisions of the contract under subsection (c), to utilize such cost containment and utilization management strategies as necessary, including generic substitution, formulary limits, differential copayment structures, and mail order prescription services, or as limiting the ability of benefit managers to offer to enrolled individuals multiple products offering different formulary and copayment structures.

''(g) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG BENEFIT MANAGERS.—During the period after the Director has given notice of intent to terminate a contract

under subsection (c), the Director may transfer responsibilities of the benefit manager under such contract to another benefit manager.

''(h) NONINTERFERENCE.—Nothing in this section or in this part shall be construed as authorizing the Director or the Secretary to authorize a particular formulary or to institute a price structure for benefits, or to otherwise interfere with the competitive nature of providing a prescription drug benefit through benefit managers.

''(i) ANTI-SELECTION CRITERIA.—The Director shall design provisions to exclude bids designed to exploit adverse selection, including the definition of a minimum geographical service area.

''SEC. 1860H. EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE.

''(a) PROGRAM AUTHORITY.—The Director is authorized to develop and implement a program under this section called the Employer Incentive Program that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (f)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Director may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Director and covered retirees—

''(i) at least 120 days before terminating its plan, and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Director, for each calendar quarter for which it seeks an incentive payment

under this section the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Director access to, such records as the Director may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and comply with such other requirements, as the Director may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate em-

ployment-based health plan) of an incentive payment, in the amount determined as described in paragraph (2), for each retired individual (or spouse) who—

"(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

"(B) was eligible for but was not enrolled in the program under this part.

"(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to two-thirds of the monthly premium amount payable by an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

"(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

"(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Director determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an

amount up to three times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) PART D ENROLLMENT FOR CERTAIN INDIVIDUALS COVERED BY EMPLOYMENT-BASED RETIREE HEALTH COVERAGE PLANS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription drug plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription drug coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to

enroll in the program under this part during the six-month period beginning on the first day of the month in which—

"(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

"(B) the individual received notice of the change in benefits (in the circumstance described in subparagraph (1)(C)(ii)).

"(f) DEFINITIONS.—As used in this section, terms have the following meanings:

"(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(2) EMPLOYER.—The term 'employer' has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of two or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value (as defined by the Director) to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' means plan sponsor as defined in section 3(16) of the Employer Retirement Income Security Act of 1974.

''(g) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under subsection (c).

''SEC. 1860I. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.

''There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Drug Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part, plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers.

''SEC. 1860J. DEFINITION.

''As used in this part, the term 'prescription drug' means—

''(A) a drug that may be dispensed only upon a prescription, and that is described in subparagraph (A)(i), (A)(ii), or (B) of section 1927(k)(2); and

''(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin.''.

(b) STUDY OF ANNUAL OPEN ENROLLMENT.—

(1) STUDY.—During 2002 and 2003, the Director of the Office of Personnel Management shall

study the feasibility and advisability of establishing an annual open enrollment period for the program under part D (as added by subsection (a)). Such study shall reflect data reported by benefit managers administering benefits under such part and shall include—

(A) a review of the costs, effectiveness, and administrative feasibility of an annual open enrollment period for beneficiaries who previously declined enrollment or who previously disenrolled and desire to re-enroll;

(B) an evaluation of a premium penalty for late enrollment based on actuarially determined costs to the program of late enrollment; and

(C) a projection of the costs to the program under such part through 2010 of an annual open enrollment period.

(2) REPORT.—The Director shall prepare a report setting forth the outcome of the study, and may include in the report a recommendation as to whether an annual open enrollment period should be implemented under such part.

(c) AMENDMENTS TO MEDICARE+CHOICE PROGRAM.—Part C of title XVIII of the Social Security Act

is amended by inserting after section 1857 the following new section:

''COVERAGE OF PRESCRIPTION DRUGS

''SEC. 1858. (a) AVAILABILITY.—

''(1) IN GENERAL.—In accordance with rules established by the Director of the Office of Personnel Management, in coordination with the Secretary, each Medicare+Choice plan shall provide, to each individual enrolled under part D, prescription drug benefits described in part D (or equivalent benefits as authorized by the Director).

''(2) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for such benefits a requirement that an enrollee pay a deductible or pay a higher coinsurance percentage than the percentage applicable under part D for the expenses involved.

''(3) AVAILABILITY OF PRICES.—Each contract under section 1857 shall provide that enrollees entitled to benefits made available under this section who exhaust the plan's prescription drug benefits will continue to have access to prescription drugs at prices equivalent to the total combined cost of such drugs to the plan and the enrollee prior to such exhaustion of benefits.

''(b) INFORMATION.—Information respecting the benefits made available under subsection (a) shall be provided in the same manner as information on other benefits provided under this part is made available.

''(c) PAYMENT.—

''(1) IN GENERAL.—In the case of a Medicare+Choice plan that provides prescription drug coverage described in subsection (a), the amount of monthly payment otherwise made to the Medicare+Choice organization offering the plan under section 1853 shall be increased by the amount described in paragraph (2). Such payments shall be made in the same manner and time as the amount otherwise paid under section 1853, but such amount shall be payable from the Prescription Drug Insurance Account in the Federal Supplementary Medical Insurance Trust Fund.

''(2) AMOUNT.—The amount described in this paragraph is the monthly premium rate under section 1860D(a)(2)(B), but subject to adjustment under paragraph (3). Such amount shall be uniform geographically and shall not vary based on the Medicare+Choice payment area involved.

''(3) RISK ADJUSTMENT.—The Director of the Office of Personnel Management may establish a

methodology for the adjustment of the payment amount under this subsection in a budget-neutral manner that takes into account the relative risks for use of outpatient prescription drugs by Medicare+Choice enrollees.

''(d) SEPARATE APPLICATION OF ACR TO PRESCRIPTION DRUG COVERAGE.—In applying section 1854 with respect to prescription drug benefits provided under this section, the Secretary shall apply the provisions of such section (including the computation of the adjusted community rate) separately with respect to such benefits.''.

(d) MEDIGAP CHANGES.—For purposes of applying section 1882(p)(1)(E) of the Social Security Act (42 U.S.C. 1395ss(p)(1)(E))—

(1) the Secretary of Health and Human Services shall be deemed to have made the determination described in such section; and

(2) in modifying standards under such section, notwithstanding the provisions of section 1882(p)(3)(A) of such Act, any coverage for outpatient prescription drugs shall be designed in a manner that does not substantially eliminate any cost-sharing with respect to prescription drug coverage.

(e) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and such amounts'' and replacing it with ''such amounts''; and

(ii) by adding the following before the period: ''and such amounts as may be deposited in, or appropriated to, the Prescription Drug Insurance Account established by section 1860F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in subsection (h), by adding at the end of the first sentence: ''and section 1860D(b)(4) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section

1860D(b)(2) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),''.

(2) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) by striking ''and'' at the end of subparagraph (H);

(ii) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

(iii) by adding after subparagraph (I) the following new subparagraph:

''(J) in the case of prescription drugs covered under part D, which are not prescribed in accordance with such part;

SEC. 3. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION DRUG COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the fourth sentence by striking ''under part B'' the first place it appears and inserting ''under parts B and D''.

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT REACHED.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(C) by adding after paragraph (65) the following new paragraph:

''(66) that, in the case of any individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1860E, the State will purchase all prescription drugs for such

individual in accordance with the provisions of such part D, without regard to whether the benefit limit for such individual under section 1860B(b) has been reached.''.

(b) MEDICARE COST SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' at the end of clause (i);

(B) by inserting ''and'' at the end of clause (ii); and

(C) by adding after clause (ii) the following:

''(iii) premiums under section 1860D,'';

(2) in subparagraph (D)—

(A) by inserting ''(i)'' after ''(D)''; and

(B) by adding at the end the following:

''(ii) The difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Director approves

a higher percentage under such section, if any reference to such percentage were deemed to be multiplied by two).

(c) MEDICARE DRUG COST SHARING REQUIRED FOR MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(v)(1) The term 'qualified medicare drug beneficiary' means an individual—

''(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Om-

nibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare drug cost-sharing' means the following costs incurred with respect to a qualified medicare drug beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

''(i) premiums under section 1860D; and

''(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if there were no coinsurance.

''(B) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage

of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

''(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.''.

(2) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) (42 U.S.C. 1396(a)(10)(E)) is amended—

(A) by striking ''and'' at the end of clause (iii);

(B) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare drug cost sharing (as defined in section 1905(v)(2)) for qualified medicare drug beneficiaries described in section 1905(v)(1); and''.

(3) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE DRUG COST SHARING.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by adding after paragraph (6) the following new paragraph:

''(7) an amount equal to 100 percent of amounts as expended as medicare drug cost sharing for qualified medicare drug beneficiaries (as defined in section 1905(v)) (except that this paragraph shall not apply to amounts expended with respect to any individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost sharing); and''.

(d) MEDICAID DRUG PRICE REBATES UNAVAILABLE WITH RESPECT TO DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription drugs purchased under part D of title XVIII pursuant to an agreement with the Director under section

1860E (including any drugs so purchased after the initial benefit limit under section 1860B(b) has been exceeded).''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to prescription drugs purchased on or after January 1, 2002.

SEC. 4. MEDPAC STUDIES ON BENEFIT MANAGERS.

(a) STUDIES.—The Medicare Payment Advisory Commission shall conduct a study on—

(1) the ability of benefit managers to improve quality and reduce costs and to assume risk;

(2) strategies to improve risk assumption by such managers;

(3) the likely effect of allowing benefit managers to vary aspects of the benefit package (such as type of cost-sharing, premium levels, and stop-loss provisions) based on costs, utilization, and access; and

(4) the use of the stop-loss provision, including analysis of benefit manager data on beneficiary utilization and the effectiveness of cost constraints once the stop-loss is triggered.

(b) REPORTS.—The Commission shall submit a report to Congress not later than 1 year after the date of

the enactment of this Act on the studies under subsection (a).

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